

# Foster Family Home - Corrective Action Report

Provider ID: 1-560393

Home Name: Madeline Sagun, RN

Review ID: 1-560393-8

91-323 Hoalauna Place

Reviewer: Jackie Chamberlain

Ewa Beach

HI 96706

Begin Date: 2/5/2020

## Foster Family Home Required Certificate [11-800-6]

6.(d)(1) Comply with all applicable requirements in this chapter; and

Comment:

6(d)(1) Home inspection made for a 2 bed re-certification. Corrective action report issued during home visit with corrective action plan due to CTA within 30 days of inspection

## Foster Family Home Client Care and Services [11-800-43]

43.(c)(3) Be based on the caregiver following a service plan for addressing the client's needs. The RN case manager may delegate client care and services as provided in chapter 16-89-100.

Comment:

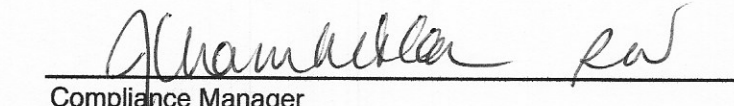
43.c.3 No RN delegation present for caregiver # 3 and # 4 for client 1 and client 2

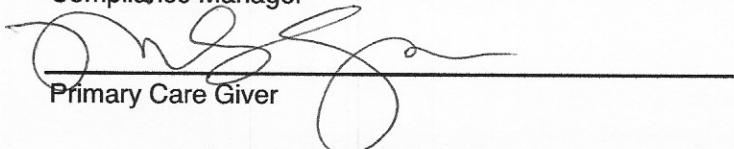
## Foster Family Home Fire Safety [11-800-46]

46.(a) The home shall conduct, document, and maintain a record, in the home, of unannounced fire drills at different times of the day, evening, and night. Fire drills shall be conducted at least monthly under varied conditions and shall include the testing of smoke detectors.

Comment:

46. (a) No fire drill conducted since January 2018

  
Compliance Manager

  
Primary Care Giver

2/05/2020  
Date

2/5/2020  
Date

Community Care Foster Family Home (CCFFH)  
 Written Plan of Correction for Deficiencies  
 Listed in Corrective Action Report  
 Chapter 17-1454

CCFFH Name: Tender Loving Foster Home / Madeline Sagan  
 CCFFH Address: 91-323 Hualauna Place Ewa Beach, HI 96706

Rule Number	Corrective Action Taken	Date Corrected	Prevention Strategy
43(c) 3	RN delegation signed by caregiver #3 and #4 with RN Case Manager for client #1 and #2	2/18/20	Home will notify CMA that RN delegation needs to be performed within 7 days
46 (a)	Lapse cannot be corrected	2/18/20	Fire drills will be done by each caregiver (at least once a year) on a monthly basis. Home set alarm notification on cellphone monthly.

Primary Caregiver's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date of Signature: \_\_\_\_\_

2/23/2020